Reference number(s)
3502-A

Specialty Guideline Management

TAZVERIK (tazemetostat)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Tazverik is indicated for the treatment of adults and pediatric patients aged 16 years and older with metastatic or locally advanced epithelioid sarcoma not eligible for complete resection.

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

Epithelioid Sarcoma
Authorization of 12 months may be granted for the treatment of metastatic or locally advanced epithelioid sarcoma when all of the following criteria are met:
A. The disease is not eligible for complete resection
B. The member is 16 years of age or older

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section II when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

IV. REFERENCES

1. Tazverik [package insert]. Cambridge, MA: Epizyme, Inc.; January 2020.